Best Practices in Egypt:
Democratization of Performance Improvement
(Clinic Management)

The CATALYST Consortium is a global reproductive health and family planning activity initiated in September 2000 by the Office of Population and Reproductive Health, Bureau for Global Health of the United States Agency for International Development (USAID). The Consortium is a partnership of five organizations: Academy for Educational Development (AED), Centre for Development and Population Activities (CEDPA), Meridian Group International, Inc., Pathfinder International and PROFAMILIA/Colombia. CATALYST works in reproductive health and family planning through synergistic partnerships and state-of-the-art technical leadership. Its overall strategic objective is to increase the use of sustainable, quality reproductive health and family planning services and healthy practices through clinical and nonclinical programs.

Mission

CATALYST's mission is to improve the quality and availability of sustainable reproductive health and family planning services.

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Democratization of Performance Improvement
(Clinic Management)

> **The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.**
>
> **Declaration of Alma Ata, 1978**

THE NEED

In Egypt, public sector health clinics provide the majority of rural health care. Of all primary health care (PHC) facilities in rural areas, 59% have a waiting area protected from the elements, a functioning latrine, and a basic level of cleanliness and hygiene; 44% have the capacity for proper sterilization or high-level disinfection; 75% have regular water and electricity supply; 28% have a preventive maintenance program for major equipment; and, 48% report no funding sources for maintenance and repairs. Clinic management is often poor. Merely 9% of all rural PHC facilities have documented, biannual management committee meetings, and only 4% of these elicit client opinion.[1]

Factors contributing to problems with clinic management include:

1. Physicians, clinic directors and other clinic staff are not trained in quality management or in managing for results. Resource management and work planning activities are centralized at the district level and limit staff's ability to take initiatives. As a result clinic staff do not feel responsible for clinic outcomes. Moreover, they have not been trained to work together as a team or to seek community input.
2. Although the Service Improvement Fund (SIF) provides a mechanism for generating and spending clinic funds, it is rarely utilized. Clinic physicians and other staff members are afraid to run afoul of rules and regulations that they may not know or understand. In addition, generated funds are managed at the district level, and clinic staff have no ownership of the SIF or knowledge about the SIF balance.
3. The clinic boards are a mechanism for involving clients, however, they are rarely used efficiently. Board members fulfill a nominal role and receive no guidance on their roles and responsibilities, including on how to involve the community.
4. The clinic staff supervision system is not designed to motivate clinic staff and board members toward greater autonomy and quality improvements.
5. Supervisors from different sectors—family planning (FP), maternal and child health (MCH) and curative care—do not have a standardized supervision system. This precludes clinic supervisors from providing a holistic approach regarding issues such as staffing, incentives, cleanliness and client satisfaction, which is important for quality of care for all services.

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1 . Ministry of Health and population [Egypt], El Zanaty Associates, and ORC Macro. 2003. *Egypt Service Provision Assessment Survey 2002*. Calverton, Maryland: Ministry of Health and Population, El-Zanaty Associates and ORC Macro.

Services provided at PHC facilities are often of low quality, staff morale is waning and clients have little trust in the quality of care provided; as a result services are underutilized.

THE TAHSEEN SOLUTION

To increase the use of the PHC clinics, TAHSEEN needed to improve clinic staff morale and management skills, facilitate access to SIF funds, increase community involvement and implement an integrated supportive supervision system.

Beginning in 2003, TAHSEEN worked with 53 PHC clinics in the Minia, Beni Suef and Fayoum governorates in Upper Egypt to strengthen quality of care. Clinics were renovated, and all staff received clinical training in the provision of integrated reproductive health/family planning (RH/FP) and MCH services in accordance with the MOHP standards of practice.

TAHSEEN worked with the Ministry of Health and Population (MOHP) to create a performance improvement program that engaged all key stakeholders—clinic staff, clients, community members and district supervisors—to become responsible for the quality of care provided at their clinic.

Preparation

TAHSEEN capitalized on an underutilized ministerial decree (Decree 239) that allowed for the creation of clinic boards who would then have access to the SIF. These funds are used to invest in the clinic and provide staff with financial incentives. In Minia, where the first clinics were renovated, TAHSEEN worked with MOHP and Ministry of Finance (MOF) governorate staff to open a community-level bank account for each clinic, as opposed to accounts controlled at the district level. In collaboration with MOF central office and governorate staff, TAHSEEN assigned MOF supervisors to countersign any checks written against a SIF by clinic boards. Once assigned, MOF supervisors met with physicians, clerks and district managers to clarify the entire system and define the role and responsibilities of each partner. This design was replicated in Beni Suef and Fayoum.

Next, a team was formed, consisting of MOHP and MOF staff from the three governorates, to draft a booklet clarifying the financial rules and regulations for the SIF. The booklet was revised and reviewed by MOF supervisors at the central level, and formally approved by the First Undersecretary of MOF and the Undersecretary of the Family Planning and Population sector of MOHP. This booklet was used in the clinic management course for clinic staff.

Implementation

TAHSEEN and its partners created a clinic management and integrated supervision course for clinic staff and supervisors. This course capitalized on the success of two previous programs: the leadership and management program that was piloted with great success in Aswan by Management Science for Health, and the improved supervision experience in Vietnam, implemented by the RH/FP Project. The course was designed with the following objectives:

- To enable clinic staff and supervisors to discuss a shared vision for the clinic and create a results-oriented culture of quality improvement, contributing to an improved work climate;
- To teach key staff members some clinic management basics (problem solving, prioritization, action planning, etc.);
- To clarify the rules and regulations on clinic management and the use of the SIF;

- To establish clinic teams that are able to draw inputs and other resources from communities and supervisors; and,
- To instill in clinic supervisors the sense that they can contribute as full partners to clinic improvements.

Achieving these objectives required not only new knowledge among the clinic staff and supervisors, but also new skills, thought processes and behaviors. TAHSEEN introduced the course through three workshops over a six-month period to give the staff a chance to absorb new concepts, and test and apply new skills.

During the workshop, staff acknowledged the challenge of working under complex and in limited resource settings. They were equipped with new skills to mobilize all available resources. They learnt to gather data in order to identify problems and challenges, and designed and implemented an action plan. They jointly evaluated the action plan as an opportunity for feedback, learning and further motivation.

The first part of the field activities included three workshops:

1. Workshop I: Clinic staff and supervisors learned to understand individual roles and responsibilities and how everyone on the clinic team can contribute to collective performance. As a physician from Taibi, Minia explained:

   > "We learned how to work in a team. Everyone sees his responsibility inside the team. We look for the results as if they are our own. Before [the Clinic Management Training], everybody was working as individuals, and they were indifferent about the outcome for the patient or the clinic. Now things are different."

   The role of the supervisor was re-defined as being that of a “coach” who facilitates improvement rather than as an “inspector”. By clarifying roles and expectations, TAHSEEN and the clinic staff created an environment where even a janitor can feel comfortable suggesting improvements, where a manager is not afraid to take a risk and where everyone knows that mistakes are opportunities for learning. The staff and supervisors learned the basics of management techniques, including problem solving.

   Staff and supervisors were then prepared to go back to their clinics to: (a) collectively gather information about their clinics through formal work climate assessments, client exit interviews, and use of an integrated quality checklist; and (b) use the collected data to identify, analyze, define the root causes of and prioritize problems affecting the quality of care provided at their clinics. For the first time, clinic staff interviewed clients to learn whether they were satisfied with services and how the clinic was viewed in the community.

2. Workshop II: This workshop took place three weeks after the first to allow enough time for data collection. Staff and supervisors presented their first collective vision of what they wanted for their clinics and their work environment as well as their analysis of the challenges they needed to overcome. They worked in teams to create realistic, results-oriented action plans that addressed their problems and allowed them to begin implementing their vision.

> “Before the training, we did everything in the clinic without a plan. Now we not only plan—we dream. Before this process, we were indifferent to numbers. Today we all watch the indicators, as they are markers for our success.” — Physician from Tayeba, Minia

Staff members learned that they cannot implement action plans alone. They realized that they needed to reach out to community partners—clinic boards, local councils and community development associations. Following the second workshop, clinic staff members implemented their first action plan with the full support of their supervisors. Three months were allowed for the implementation of the action plans.

3. Workshop III: Workshop III took place three months after the second. All participants assessed the effectiveness of their actions, shared their achievements, lessons learned and next steps. Supervisors assisted clinic staff in identifying areas that still required improvement, so the cycle could continue.

> "I learned the power of positive encouragement and immediately took this approach with my staff. These skills are not taught in medical school. Before this program, nothing had prepared me to manage clinic staff." — Physician from Nazlet El Amoden, Minia

To increase community involvement in clinic management, TAHSEEN turned to Decree 239, which allowed for the creation of clinic boards. As noted earlier, these boards were largely inactive and tended to lack female and community representation.

As a first step, TAHSEEN worked with clinics to reconstitute their boards. Criteria for members were developed with clinic teams, district managers and community representatives, such as nongovernmental organization (NGO) directors, local councils and mayors, and all suggested candidates to serve on the clinic board. An equal representation of community members and clinic staff as well as men and women was encouraged. Candidates who agreed to serve made up the board and, when needed, replacements were found. The Undersecretary of Health presented the proposed board to the Governor for approval, who then issued a decree for the constitution of the board. The Governor also addressed the newly appointed board members, urging them to do their best to ensure that the clinics were responsive to the community.

Once the board was created, TAHSEEN trained the new clinic board members to:

- Increase their knowledge of leadership, problem identification, decision making and problem solving;
- Increase their skills in generating funds for the clinic through social responsibility activities; and,
- Increase their capacity to link the clinic to the community.

TAHSEEN used a two-phase training program similar to the clinic staff and supervisor training to help board members to work together with clinics and communities to improve clinical services, increase clinic resources and help clinics become more responsive to the community needs.

1. The first workshop clarified the responsibilities of board members and trained the members on how to conduct meetings. The board members were introduced to the

SIF. They also were asked to assess the community's current view of the clinic and to speak with clinic teams to understand their action plans and needs. Two to three weeks were allocated for this activity.

2. The second workshop trained board members on SIF rules and regulations and on conducting fund generating activities. The workshop was also used to assess community perceptions of and attitudes towards the clinics and to brainstorm approaches that can be used to connect the clinic to the community. The group then drafted a plan for community mobilization (CM) and generating funds.

All 53 TAHSEEN clinics in Minia, Beni Suef and Fayoum now have functioning boards, which include an equal number of men and women and an equal number of clinic staff and community members. A total of 596 board members have been trained in a two-phase program to prepare them to assume their duties. Clinic boards have conducted meetings, implemented their action plans and mobilized resources and support for their clinics. Because clinic staff members have learned how important community input is in defining quality and increasing the resources available to them, these boards are welcomed by their clinics.

RESULTS

The introduction of this three-tiered approach (clinic management training for staff and supervisors, coordination of district-level supervision and community mobilization through clinic boards) contributed to system-wide changes. Clients increasingly used services; staff members were more confident about their roles; and communities mobilized unprecedented levels of resources for their clinics. With the support of supervisors and communities, clinic staff made quality improvement part of their everyday tasks. The clinic boards assisted each clinic with setting quality of care goals and creating a three-month action plan to reach these goals. All key stakeholders at the district, clinic and community levels recognized the role they had to play to strengthen quality of care at their local clinic.

For example, at the clinic level, a FP nurse, who was not used to making suggestions, now works as part of a team to identify challenges and implement solutions. At the district level, a supervisor, who once only reviewed FP activities, sees the "big picture" at a clinic and becomes involved in noting problems and developing solutions. And at the community level, a school teacher from Minia, who once was concerned about the high school drop-out rate among girls, is now constructively involved in encouraging delayed marriage through her clinic board. Many stakeholders envision a better future for their community because they know they can make decisions, implement change and make a difference.

Supervisors now work in a supportive fashion to assist clinic staff and look at a clinic's overall performance as a team. To assess performance, these supervisors use an integrated quality checklist developed by TAHSEEN and the MOHP. Because the checklist was standardized, it eventually can be adopted throughout the MOHP system, allowing the MOHP to monitor and compare quality of care at clinics nationwide. Performance data gathered with this checklist also contributed to a revised incentive system that was more transparent and more clearly linked to group performance. The on-the-job training coaches used the same checklist.

Clinic staff, clinic board members and the community now have the skills, tools, support and resources needed to realize their own vision of what their clinic can be. Specific results include:

Improved work climate and staff morale

Clinic staff conducted quarterly work climate assessments to measure the challenges faced by staff, the support available to staff and staff members' clarity about their roles and responsibilities. Before and after the Clinic Management and Integrated Supervision training, a series of questions were used to determine whether staff members felt supported by their supervisors and the clinic team, whether they perceived issues arising in the workplace as challenges or problems and the clarity of their roles and the roles of other team members.
The results showed an increased sense of support (from 50% to 85%), an increased view of issues as challenges (54% to 90%) and an increased clarity regarding roles (45% to 89%) (all changes $p<0.001$).

Improvements in the work climate are critical—the more people are satisfied with their workplace, the more they are motivated to make a difference at work. As a result of the training, clinic staff and supervisors often voluntarily increased their responsibilities to achieve clinic goals. On several occasions, individuals expanded their own workload: nurses cleaned rooms to ensure the highest levels of infection control, community outreach workers conducted additional meetings to inform the community about services, staff members invested their own resources into clinic facilities and nurses increased screening responsibilities with patients to help physicians with the additional workload. This commitment can be attributed to a new clinic environment where each staff member understands his/her critical role in improving quality of care.

Improved clinic management

Improved clinic management was evident in the score on the integrated supervision checklist used by district supervisors and coaches to track changes and measure improvements in infection prevention, logistics management, equipment and maintenance and clinic management.

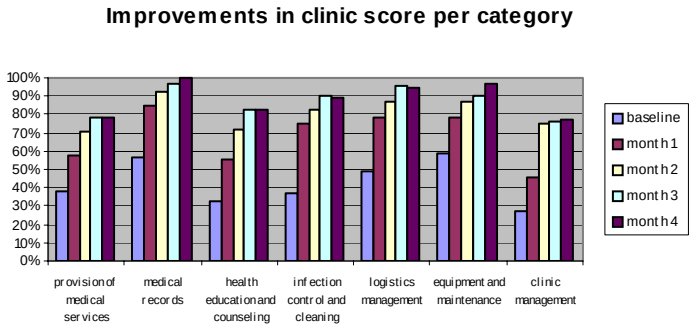

Figure 1. Average score on Integrated Checklist

Improvements have occurred in all topic areas (see Figures 1 and 2). The average increase was from 39% at baseline to 87% after four months of intensive on-the-job training.

On-the-job training has proven to be highly acceptable to the MOHP and helped change behaviors among clinic staff to support integrated management and care activities. As a result, the MOHP requested TAHSEEN to develop an on-the-job training course for district supervisors, thus scaling-up on-the-job trainings to the national level.

Availability of SIF funds and clarity in procedures

As described above, working with the MOF resulted in the production of a booklet that clearly describes SIF rules and regulations. This booklet was distributed to all board members.

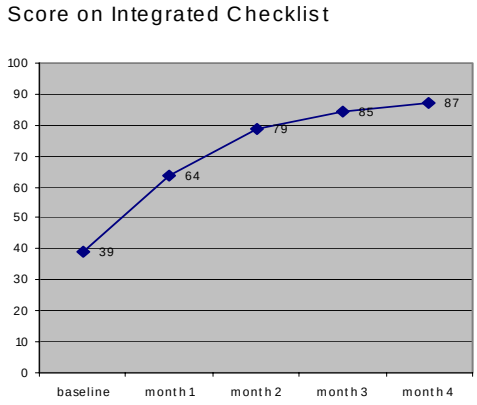

Figure 2. Average score on Integrated Checklist

SIFs were reactivated in 53 communities, and finance staff was trained in how to use the funds. Cash contributions, whether individual or corporate, are channeled through the SIF. Checks and balances also are built into the system. For example, the donors' names and the cash flow details are posted outside every clinic. This transparency builds community trust. A total of 80 checks have been written since July 31, 2005.

Community member participation is fully supported by the authorities. In the first quarter after the intervention, a total of 28 clinics received donations from authorities at the governorate level, and 29 received in-kind donations. For example, the Governor of Minia has allocated 100,000 EGP to the SIFs of the clinics.

Community involvement through functioning boards

The reactivation of the clinic boards in all 53 clinics has been a catalyst for community mobilization and resource mobilization. Local clinic boards are taking measures to improve the health of their communities by mobilizing human and financial resources and linking with other civic institutions, such as local councils, school boards, NGOs and CDAs. Joint activities are becoming commonplace and leading to village-wide mobilization efforts to plant trees, clean streets, subsidize treatment for the needy and provide awareness-raising campaigns or free consultations. In many communities, board members solicited cash donations from individual households with people willingly contributing to the reactivated SIFs according to their means. Clinic boards are widening the net of "social responsibility" in their effort to generate new resources.

To date, 16 clinics have received cash donations from local community members, and 16 clinics have received in-kind contributions.

One rural clinic board plans to obtain large tents through local business contributions and rent them out for special events, such as weddings. Such a service would meet a community need, generate income for the clinic, acquaint large numbers of people with the renovated clinic and possibly offer clinic staff access to engaged and newly married couples for counseling. Another board is looking into allowing a company to sell health and hygiene products within the clinic in return for a share of the profits.

In Tayeba, local businesses approached by clinic board members donated funding to improve seating in the waiting area and have also agreed to continue funding an integrated RH/FP/MCH in-service training program for clinic staff once USAID funding is phased out. In Shedmo, the clinic board mobilized the donation of a car to transport outreach workers to the outlying hamlets, and individuals were mobilized to donate medicine and cleaning products.

In Mansheit Abdel Megid, the board approved a plan to conduct home visits in outlying hamlets and provided hamlet residents with transportation to the clinic. In Sheikh Hassan, clinic board members donated their representation fees to the SIF and contacted pharmaceutical companies and businessmen for contributions. The board in Mansheit Faisal arranged for a car to bring clients from neighboring hamlets to the clinic and initiated an incentives system for outreach workers. Community residents in Metartares donated 850 EGP during a community "action day" when youth, NGOs, the clinic and the local council planted trees, held RH/FP awareness-raising sessions and cleaned village streets.

This new spirit in the communities, which is supported by the local authorities, is the key ingredient in the sustainability of the interventions. By involving the clinic staff and community in the process of change, the project has broadened. The factors critical to sustainability have moved beyond "receiving government funds" to the mobilization of funds through local donations, improved financial and administrative management, reactivation of the SIFs, and NGO and community involvement.

Integrated supportive supervision

The Undersecretary of FP and Population Sector and the Undersecretary of the Integrated Health Care and Nursing Sector formally approved the integrated supervision program. Although joint visits are taking place, there are many items that have not yet been addressed, such as the difference in incentive systems, which hinders wider implementation of joint supervision visits such for supervisors from the different sectors. These issues still need to be clarified to guarantee the implementation of the system beyond the TAHSEEN intervention areas.

In an external evaluation by MOHP central office staff, supervisors' attitudes have changed as they have become more supportive according to the physicians and nurses in the PHC facilities.

Increased utilization of services

There has been a considerable increase in the use of clinic services, which can be attributed, at least in part, to all project activities (see Figure 3). After one year of operations, data is available for the first five clinics, where service statistics for the last quarter show a 128% increase in caseload, 105% increase in couple years protection and 11% increase in the average number of antenatal care visits per pregnancy over baseline. For the second group of 48 clinics, a comparison was made between the activities in the first quarter after reopening (Q2 2005 or endline) and the same quarter before the intervention (Q2 2004 or baseline), which showed a 26% increase in caseload and 29% increase in CYP. The long-term results are expected to be similar to those of the first five clinics.

Since starting activities, the total number of people served in these clinics is over 255,000. This increase in use was confirmed through household surveys conducted in five pilot communities. In each, a systematic random sample of 200 married women of reproductive age (MWRA) were interviewed. The percentage of women who reported anyone in the household visiting the PHC center in the previous six months increased for all MWRA (from 73% to 94%, $p < 0.01$) and for young, low parity women (from 87% to 98%, $p<0.05$).

Support for program scale-up

TAHSEEN could not scale-up this program without full district and governorate support, and this support would not have been forthcoming if district and governorate leaders were not impressed with the program's success. From an initial five clinics in Minia (starting in August 2003), the program expanded to a total of 24 clinics in Minia, 14 clinics in Beni Suef and 15 in Fayoum, as of June 2005.

Memorandums of understanding (MOUs) were signed between the MOHP, clinic boards, village heads, city heads and the Sustainability Committee. The MOUs were endorsed by the governors, signaling their intention to sustain the momentum of change.

The Minister of Health and Population also indicated that he would like to see the program implemented in at least 200 clinics throughout Upper Egypt.

Sustainability

To ensure the application of new clinical and management knowledge and skills in renovated clinics, TAHSEEN developed a state-of-the-art on-the-job-training program to strengthen clinic staff skills.

To build local capacity for future needs, all OJT coaches were selected from district hospitals. These coaches were trained to be role models to clinic staff and to provide follow-up assistance on a broad range of management and clinical skills introduced in TAHSEEN training programs. In March 2005, OJT teams comprised of a physician and a nurse began visiting five clinics per week in the governorates of Minia (5), Fayoum (3) and Beni Suef (3).

Weekly visits to each clinic strengthened new management techniques. Areas that were followed up included action plan implementation, meeting skills for clinic board meetings, clinic accounting, community resource mobilization and clinical skills, such as client assessment and counseling, infection control, referral, cleaning and record keeping. OJT teams also provided technical assistance based on the needs of each clinic staff.

To sustain these activities, the highest civil authority at the governorate level needed to politically support the clinics, the boards and the community activities and to provide a forum that could address their problems. In each governorate, the Governor created a Sustainability Committee. The Sustainability Committee was comprised of MOHP, MOF, NGO and business community representatives, religious leaders, media professionals and governorate officials. The Sustainability Committee is responsible for following up and supporting the replication and sustainability of the TAHSEEN integrated model.


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